

**ORENCIA (ABATACEPT)
INFUSION ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- TB and Hepatitis B documentation

Patient Name:	DOB:
Allergies:	Patient Phone:

- Diagnosis:** Systemic Lupus Erythematosus (ICD-10 Code: _____)
- Rheumatoid Arthritis (ICD-10 Code: _____)
- Juvenile Idiopathic Arthritis (ICD-10 Code: _____)
- Psoriatic Arthritis (ICD-10 Code: _____)

J Code: J0129

ORENCIA ORDERS

Orencia Dose: _____ mg	Patient Weight: _____ kg
Frequency: <input type="checkbox"/> Every 4 weeks or <input type="checkbox"/> 0, 2, 4 - Every 4 weeks	Refills: _____
Protocol Pre-Medication Orders: <input type="checkbox"/> Tylenol 1000mg PO <input type="checkbox"/> Cetirizine 10mg PO <input type="checkbox"/> Diphenhydramine 25mg PO <input type="checkbox"/> Loratadine 10mg PO	
Additional Pre-Medication Orders: <input type="checkbox"/> Solu-Medrol _____ mg IVP <input type="checkbox"/> Solu-Cortef _____ mg IVP	
Required labs to be drawn by: <input type="checkbox"/> Infusion Center <input type="checkbox"/> Referring Physician	
Lab orders: _____ Frequency: _____	

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	